STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

CNMI Medicaid Agency will reimburse Commonwealth Health Center (CHC) at cost for Medicaid outpatient hospital services. CHC, a governmental hospital, uses the CMS-2552 cost report for its Medicare program and submits this cost report each year to the Medicare contractor. CHC will utilize the protocol outlined below to determine the allowable Medicaid hospital costs to be certified as public expenditures. CHC and CNMI use the annual period from October 1 through September 30 as their fiscal year.

I. Summary of CMS-2552-10

Worksheet A:

Worksheet A is the hospital's trial balance of total expenditures by cost center. The primary groupings of cost centers are:

i. General Service;
ii. Routine;
iii. Ancillary;
iv. Outpatient;
v. Other Reimbursable and Special Purpose; and
vi. Non-Reimbursable.

Worksheet A also includes A-6 reclassifications (which move costs from one cost center to another) and A-8 adjustments (which can be increasing or decreasing adjustments to cost centers). Reclassifications and adjustments are made in accordance with Medicare cost and reimbursement principles.

Worksheet B:

Worksheet B allocates overhead costs (identified in General Service Cost Centers, lines 1-23 of Worksheet A) to all cost centers, including non-reimbursable cost centers identified in lines 190-194 and their subscripts.

Worksheet C:

Worksheet C computes the cost-to-charge ratio for each cost center. The total cost for each cost center is derived from Worksheet B, after the overhead allocation. The total charge for each cost center is determined from the provider's records and reported on Worksheet C. The cost-to-charge ratios are used in the Worksheet D series.

Worksheet D:

Worksheet D series apportions the total costs from Worksheet B different payers/programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. Routine cost centers are apportioned based on per diem amounts, while ancillary cost centers are apportioned based on cost-to-charge ratios. Note however CHC, for Medicare cost reporting purposes, does not fully complete Worksheet C or Worksheet D of the CMS-2552, as Medicare allows for an alternative cost apportionment methodology to determine allowable program costs. Additional settlement worksheets outside of the CMS-2552 are used specifically to determine CHC's Medicare program costs.

Notes:

For purposes of utilizing the CMS-2552 cost report to determine Medicaid reimbursement described in the subsequent instructions, the following terms are defined:

- The term "finalized" refers to the cost report that is settled by the Medicare contractor with the issuance of a Notice of Program Reimbursement.

- The term "as-filed" (or "filed") refers to the cost report that is submitted by the hospital to the Medicare contractor and is typically due five months after the close of the cost reporting period.

- Any revision to the finalized CMS-2552 cost report as a result of Medicare appeal or re-openings will be incorporated into the final determination.

II. Certified Public Expenditures - Determination of Allowable Medicaid Hospital Costs

To determine CHC's allowable Medicaid costs and associated Medicaid reimbursements when such costs are funded by CHC through the certified public expenditures (CPE) process, the following steps must be taken to ensure Federal financial participation (FFP):

Interim Medicaid Outpatient Hospital Payment

The Territory will make interim Medicaid outpatient hospital payments to approximate the Medicaid outpatient hospital costs eligible for Federal financial participation claimed through the CPE process. This computation of establishing interim Medicaid outpatient hospital payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

The process of determining the allowable Medicaid outpatient hospital costs eligible for FFP begins with the use of CHC's most recently filed Medicare 2552 cost report.The following cost protocol follows the cost methodology employed by Medicare for CHC. CNMI must submit a State plan amendment to revise this cost protocol to reflect any future changes in how Medicare computes costs for the hospital.

TN No. 12-004A
Supersedes
TN No. N/A

Approval Date SEP 20 2012

Effective Date 1/01/2012

a. Total allowable hospital costs, consistent with Medicare cost principles, are reported by cost center in the CMS-2552-10, Worksheet B, Part I, Column 26.

b. For each hospital ancillary cost center (except for Renal Dialysis and Ambulance Services):

- A cost-to-charge ratio is computed by dividing the cost for the cost center as reported on Worksheet B, Part I, Column 26, by the aggregate hospital ancillary charges. The aggregate hospital ancillary charge amount is net of renal dialysis and ambulance charges, is derived from auditable hospital records, and is the same amount used for Medicare settlement purposes.

- The cost-to-charge ratio is multiplied by the aggregate Medicaid outpatient hospital fee-for-service ancillary charges, excluding any charges pertaining to Medicare-Medicaid dual eligible individuals. The aggregate Medicaid outpatient hospital ancillary charge amount is net of renal dialysis and ambulance charges and is derived from either CNMI paid claims data or the hospital's auditable records of billed and adjudicated Medicaid claims. The Medicaid charges must pertain to covered and reimbursable outpatient hospital services in accordance with the CNMI State plan. The result is the computed Medicaid outpatient hospital cost for each hospital ancillary cost center, except for renal dialysis and ambulance services.

The ancillary cost centers included should only pertain to hospital services and exclude any non-hospital services such as clinics that are not recognized as hospital outpatient departments or FQHC/RHC clinics which are separately reimbursed as non-hospital services. Non-reimbursable cost centers from the cost report should also be excluded.

c. For Renal Dialysis ancillary cost center:

- A cost per visit amount is computed by dividing the cost for the cost center as reported on Worksheet B, Part I, Column 26, by the total hospital renal dialysis visits, as reported on Worksheet I-4, Column 1, line 1.

- The cost per visit is multiplied by the number of Medicaid outpatient fee-for-service renal dialysis visits, excluding any visits pertaining to

Medicare-Medicaid dual eligible individuals. The number of Medicaid outpatient visits is derived from either CNMI paid claims data or the hospital's auditable records of billed and adjudicated Medicaid claims. The Medicaid outpatient visits must pertain to covered and reimbursable outpatient hospital services in accordance with the CNMI State plan. The result is the computed Medicaid outpatient hospital cost for the Renal Dialysis cost center.

d. For Ambulance Services ancillary cost center:

- A cost per trip amount is computed by dividing the cost for the cost center as reported on Worksheet B, Part I, Column 26, by the total hospital ambulance trips. The number of total hospital ambulance trips is derived from auditable hospital records, and is the same amount used for Medicare settlement purposes.

- The cost per trip is multiplied by the number of Medicaid outpatient fee-for-service ambulance trips, excluding any trips pertaining to Medicare-Medicaid dual eligible individuals. The number of Medicaid outpatient trips is derived from either CNMI paid claims data or the hospital's auditable records of billed and adjudicated Medicaid claims. The Medicaid outpatient trips must pertain to covered and reimbursable outpatient hospital services in accordance with the CNMI State plan. The result is the computed Medicaid outpatient hospital cost for the Ambulance Services cost center.

e. For Inter-Island Referral Transportation costs:

- Transportation costs incurred by the hospital for inter-island referrals to the hospital are added to the allowable costs computed above. These costs are not recognized in a reimbursable cost center on the Medicare cost report. However, these costs are reimbursable as Medicaid allowable costs as the transportation services are covered Medicaid services.

- The hospital will determine Medicaid's share of the transportation costs based on auditable documentation of travel authorization and invoices for Medicaid recipients, The hospital pays the transportation contractor at the standard rate for all payers. Since such travel costs are recorded and directly assigned to individual patients, there is no need to apportion total transportation costs to Medicaid using an apportionment statistic. The Medicaid costs

identified must only pertain to Medicaid fee-for-service individuals and should exclude any costs pertaining to Medicare-Medicaid dual eligible individuals.

The Medicare CMS-2552 is due to the Medicare contractor five months after the close of the hospital's cost reporting period. The interim reconciliation will be performed and completed within six months of the filing of the Medicare CMS-2552.

Final Reconciliation of Interim Medicaid Outpatient Hospital Payments

CHC's final Medicaid outpatient hospital payments will be reconciled to its Medicare CMS-2552 cost report as finalized by the Medicare contractor for purposes of Medicare reimbursement for the respective cost reporting period.

The hospital's Medicaid outpatient hospital costs will be computed using the same methodology described in steps a-f above but using cost data from the finalized cost report for the respective expenditure period. Additionally the days, charges, visits, and trips data from CNMI or provider auditable sources will be based on services furnished during the expenditure period, and the revenue offsets in step f would be updated to account for revenues for services furnished during the expenditure period. The Medicaid outpatient hospital cost will be compared to the interim Medicaid outpatient hospital payments made, including any interim reconciliation amounts. Any underpayment will be claimed as additional hospital payments for the expenditure period, and the federal share will be paid to the hospital. Any overpayment will be recorded as a reduction to the hospital payment amount for the expenditure period, and the federal share will be returned to CMS.

The final reconciliation will be performed and completed within six months of the Medicare contractor's finalization of the Medicare CMS-2552 with the issuance of a Notice of Program Reimbursement.